Application for Trauma Service Designation

Level III

2004 – 2006 Designation Cycle

Office of Emergency Medical Services and Trauma System

Mailing Address
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360-236-2871

TRAUMA SERVICE DESIGNATION APPLICATION PACKET CONTENTS

INFORMATION

1. GENERAL INFORMATION

1.1 History and Purpose

In March 1990, the Washington State Legislature passed RCW 70.168, the "Statewide Emergency Medical Services and Trauma Care System Act." This act mandated that the Department of Health (DOH) develop a comprehensive emergency medical services and trauma care system. DOH was given authority to designate hospitals and other health care facilities to provide trauma care services for adult and pediatric trauma patients through the rehabilitation phase. Every three years, DOH releases an application for trauma service designation. All hospitals and other health care facilities seeking to provide trauma care services must complete an application. DOH designates facilities based on the evaluation of applications in accordance with standards identified in Washington Administrative Code (WAC) 246-976.

1.2 Washington Administrative Code 246-976-430 thru 910

This application for trauma service designation is based on WAC 246-976-430 thru 910, revised and effective January 2004. These WAC's are Washington State's standards for trauma care for all designated trauma services. The applicable standards are listed in the Trauma Service Component section of this application and listed as Trauma Service Administration, Trauma Team Activation, etc. All other referenced WAC's are provided in the Exhibit section of the application. Do not use any other versions of WAC 246-976 to complete this application. WAC 246-976 in its entirety is online at www.doh.wa.gov/hsqa/emstrauma/wacindex.htm.

1.3 Minimum/Maximum Numbers and Trauma Service Levels

The numbers and levels of trauma services designated within each EMS and Trauma Care Region will be based on the minimum and maximum (min/max) numbers approved by DOH for every level of trauma service. (Min/max numbers were provided in the application announcement packet.) A facility, whether previously designated or not, may apply for trauma service designation at the level deemed appropriate by its administration and in accordance with the min/max numbers established by its region. Competition for designation exists within a region when the number of facilities applying for a specific level of designation exceeds the maximum number of trauma services allowed.

2. APPLICATION INFORMATION

2.1 Designation Schedule

The DOH releases applications for all levels of designation, in each region, according to the application schedule. (The schedule was provided in the application announcement packet. You can obtain an additional copy at www.doh.wa.gov/hsqa/emstrauma/download/desigappsched.pdf.) You will be notified immediately if a change to the schedule affects your facility.

2.2 DOH Application Contact

All communication concerning the interpretation of content, clarification of the process, or requests for additional materials, must be directed to the DOH application contact identified below. Oral communication not confirmed in writing by the application contact will be considered unofficial and will not bind the Department of Health. The DOH application contact is:

Sandi Shaw, Trauma Service Designation Coordinator
Phone: 360-236-2871 or toll free 1-800-458-5281 (*in-state only*, *option 3***)**
Email: sandi.shaw@doh.wa.gov
Address: WSDOH
Office of EMS & TS
310 Israel Road SE
PO Box 47853
Olympia WA 98504-7853

2.3 Application for Trauma Service Designation

This document is the official trauma service designation application for the 2004-2006 designation cycle. Any previous versions of this application will not be accepted.

The Department of Health reserves the right to make corrections or amendments to the application. Corrections will be provided immediately, at no cost. Materials submitted in response to the application become the property of DOH. Selection or rejection of an application does not affect this right.

You have 90 days to complete the application, per WAC 246-976-485. The application, in its entirety, must be postmarked by the due date for your region, which is provided on the application schedule. There is no need to send your application via certified mail, or to incur overnight shipping costs. Please check with the application contact if there is a perceived problem. Send your application to **Sandi Shaw** at the address above.

2.4 Format and Copy Instructions

DOH copy: Your application must be submitted on standard 8½" x 11" white paper, double-sided where possible (do not copy to the front or back of tab pages or to the back of the component page), no staples, plastic covers, or binders. 3-hole punch the document all at once so the pages fit in the application binder on file at DOH. Each section of the application must be separated by a labeled tab divider page (not numbers); e.g., Certifications and Assurances, Trauma Service Profile, (create a tab for each Trauma Service Component; e.g., Trauma Service Administration), Staff Resource List, Scope of Trauma Service, and Registry Reports. After each tab, insert the corresponding application page, followed by your responses to all questions and any requested documentation. Special packaging is not required for the DOH copy; just use a rubber band, binder clip, or such.

Physician and nurse reviewer copies: Provide the appropriate number of copies using most of the same instructions as for the DOH copy, however in a bound form. (A spiral binding is best, which can be done at a copy shop if not available at your facility. Make sure the copies are tabbed also.)

Level III – 2 additional bound copies of the application
Level III pediatric – 1 additional bound copy of the application.

2.5 Withdrawal of an Application

You may withdraw a submitted application at any time, up to the application due date. A written request, signed by an authorized representative of your facility, must be submitted to the application contact indicated in section 2.2. After withdrawing an application, you may submit another application at any time, up to the application due date.

2.6 Proprietary Information and Public Disclosure

Your application, when received by DOH, is confidential until the contract resulting from this process, if any, is signed by your facility's signing authority and then the Department's Contracts Officer or designee. Thereafter the application will be deemed public record as defined in RCW 42.17.250 to .340. In the event you choose to claim portions of the application as exempt from disclosure, under the provisions of RCW 42.17.250 to .340, it is incumbent upon you to clearly identify those portions of the application by page number and particular exception(s) from disclosure, upon which you are making that claim. Each page claimed to be exempt from disclosure must be clearly identified by the word "confidential" printed on the upper right-hand corner of the page. DOH will consider your request for exemption from disclosure; however, DOH will make a decision predicated upon the applicable laws. An assertion that an entire volume of the application be exempt from disclosure will not be honored.

Responses to a request to view or copy an application shall be according to agency public disclosure procedures. If any information is marked as proprietary in the application, such information shall not be made available without giving you an opportunity to seek a court order preventing disclosure.

2.7 Fee

All facilities applying for level III trauma service designation (adult and/or pediatric) will be assessed a fee to defray the cost of the site review. The fee will be due no later than 30 days prior to your site review. You will receive a letter identifying your facility's site review date, the fee, and when it will be due. If the following fees do not apply to your trauma service, other fees for alternate designation combinations can be obtained from the application contact.

Level III	$1,950
Level III & Level III Pediatric	$5,000
Level III **&** Level III Pediatric Joint	$7,000
Level III Tri-Joint	$4,250

3. DESIGNATION EVALUATION PROCESS

3.1 **Administrative Evaluation**

DOH staff evaluate your application for completeness and compliance with administrative and format requirements, as specified within the information and instruction sections of this application.

3.2 **Clinical Evaluation and Site Review**

Clinical providers, who are experts in trauma care, evaluate your application for the appropriateness and quality of trauma care in accordance with the Washington State trauma care standards, WAC 246-976, which are provided in this application. The clinical evaluation also includes a site review which entails a facility tour, staff interviews, and medical record and quality improvement review. You will be notified of the site review date and team members no later than three weeks prior to the review.

3.3 **Final Report**

You will receive a written final report summarizing the Department's administrative review of your application, and the clinical peer review of your application and facility. Any additional requirements for designation will be listed within the report. The report is due to you no later than 90 days after your site review. In regions where there is competition for designation, the final report is sent within 90 days of announcing designation decisions.

4. DESIGNATION DECISIONS, CONTRACT, and OTHER INFORMATION

4.1 **Designation Decisions**

The department will designate the facility it considers most qualified to provide trauma services. The decision to designate is based on the:

- Evaluation of all applications submitted;
- Recommendations from the site review team;
- Trauma patient outcomes during the previous designation period;
- The impact of designation on the effectiveness of the trauma system;
- Expected patient volume of the area;
- The number, levels, and distribution of designated trauma services established in the regional EMS/TC plans;
- Each applicant's ability to comply with regional EMS/TC plan goals; and
- Each applicant's compliance with its designation contract during the previous designation period.

In regions where competition for designation exists, and the evaluation of applications produces results that are substantially equivalent, DOH reserves the right to award designation to the facility whose application is considered in the best interest of the Department and the Trauma System. The criteria and procedures used to make such a determination will be communicated to the unsuccessful facility in such an event.

To ensure adequate trauma care in a specific area of the state, DOH may provisionally designate a facility that is not able to meet all the requirements of WAC 246-976. A provisional designation will not be for more than two years. Designation decisions are announced in writing, after all applications (Levels I-V) have been evaluated and site reviews completed. Decisions are announced for an entire region, no later than the date indicated by the application schedule.

4.2 Designation Contract

A successful applicant must enter into a contractual agreement with the DOH to provide trauma services. The contract period for designation is a maximum of three years. The applicant must adhere to the requirements outlined within the contract once trauma service designation is awarded.

4.3 Protest Procedure

Applicants may appeal a denial of designation decision in accordance with the provisions of chapter 34.05 RCW and chapter 246-10 WAC, the Administrative Procedure Act. Applicants who receive a denial notification letter will have 28 days from receipt of the letter to apply for an adjudicative proceeding. Instructions for applying for adjudication will be included in the letter.

4.4 Non-endorsement

As a result of selection, DOH is neither endorsing nor suggesting that your service is the best or only service. You agree to make no reference to DOH or the State in any literature, promotional material, brochures, sales presentation, or the like, without the express written consent of DOH or the State.

APPLICATION

INSTRUCTIONS

This application requires responses in the six key areas listed. Create a tab page for each of the six topics, including a tab for every Trauma Service Component. The application must be completed and submitted by the application due date. The application must be completed in the format described in **Section 2.4**, using the following instructions:

1. **Certifications and Assurances –** Obtain all the appropriate signatures.

2. **Trauma Service Profile –** Provide year 2004 data where requested.

3. **Trauma Service Components –** This section is organized by key trauma service components such as: Trauma Service Administration, Trauma Team Activation, Emergency Department, etc. Trauma standards of care, as established in Chapter 246-976 WAC, are provided for each trauma service component. You will need to indicate whether your service meets the standards of care by answering all questions and providing supporting documentation. You need to respond in the following two ways for each component:

   a. **Assurance -** If your service meets all of the standards of care for a component, check the box in the Assurance section to indicate, "meets standards." If your service does not meet all of the standards of care for that component, check the box to indicate, "does not meet the standards." (*To record your response electronically, position your cursor over the appropriate checkbox and click. This "activates" the checkbox, or re-click to "deactivate" it.*) If your facility does not meet all of the standards of care, list which standards are not being met and describe what is being done to bring the service into compliance, with an expected completion date.

   b. **Documentation -** All requested documentation must demonstrate your facility's compliance with the standards of care. Documents must be labeled and numbered to correspond with each request for information. Documentation must be in order and inserted after the appropriate trauma service component.

4. **Staff Resource List with Education & Training –** (*To complete the tables electronically, click on a shaded rectangle, and then type your response. You can use the tab key to progress through the document.*)

5. **Scope of Trauma Service –** Complete the questions in this section of the application to provide an overview of your trauma service's scope of trauma care. (T*o complete the document electronically, follow the instructions provided.*)

6. **Trauma Registry Reports –** (*Follow the instructions provided.)*

Note: DOH may request additional documentation and information during the site review. This information must be readily available and consists of any trauma related polices, procedures, protocols; call schedules; education verification; transfer agreements; etc., or similar information.

CERTIFICATIONS AND ASSURANCES
Level III

We, the undersigned, make the following certifications and assurances as a required element of the attached application for trauma service designation, understanding that the truthfulness of the facts affirmed here and the continuing compliance with these requirements are conditions precedent to the award or continuation of the related contract(s):

1. Our application for trauma service designation is true and accurate. If for any reason a part of this application changes, we will contact the DOH in writing with the change.

2. In preparing the application, we have not been assisted by any current or former employee of the state of Washington whose duties relate (or did relate) to this application, and who was assisting in other than his/her official, public capacity.

3. We understand that the DOH will not reimburse us for any costs incurred in the preparation of this application. This application becomes the property of the DOH, and we claim no proprietary right to the ideas, writings, items, or samples.

4. We are able to comply with regulations promulgated under Chapter 246-976 Washington Administrative Code. If designated, we will comply with all requirements contained in the trauma service designation final report, and the designation contract prepared by the DOH—the general terms, conditions, and statement of work.

5. We assure the commitment of hospital financial, human, and physical resources to treat all trauma patients at the level of designation approved.

6. We are also committed to providing injury prevention education to our community.

7. We understand that the DOH is not liable for any errors, omissions, or misrepresentations contained in our facility's application for designation.

8. We understand that the DOH reserves the right to refrain from designating or contracting with any applicant. The release of this application does not compel the DOH to designate or contract.

9. We endorse and fully support this application for, and maintenance of, a Level III Trauma Service, and further support this facility's participation in the statewide trauma system.

Chairman/President of governing body	Date	Administrator	Date
Trauma Service (Medical) Director	Date	Trauma Service Coordinator (RN)	Date

TRAUMA SERVICE PROFILE
Level III

Name of Facility (*name to appear on designation certificate*)	County EMS/TC Region Phone Fax
Physical Address (*street & number*)	City Zip
Mailing Address (*if different*)	City Zip

Personnel Information

Facility Administrator Phone Email Fax	ED Medical Director Phone Email Fax
Trauma Service Director (TSD) Medical specialty Phone Email Fax TSD address (if different)	Critical Care Medical Director Phone Email Fax
	Trauma Registry Coordinator Phone Email Fax
Trauma Service Coordinator Phone Email Fax	Application Contact, if not TSC Phone Email Fax

Facility and Trauma Service Statistics (use year 2004 data)

Emergency Department census	
Staffed hospital beds	
Staffed beds in the ED	
Staffed beds in the Critical Care Unit (average)	
Number of operating rooms available for trauma	
Physicians on medical staff	
Average hours per month dedicated to Trauma Service (Medical) Director responsibilities	
FTE allotted to Trauma Service Coordinator activities	
FTE allotted to Trauma Registry Coordinator activities	

TRAUMA SERVICE COMPONENTS

1. Trauma Service Administration
2. Trauma Team Activation
3. Emergency Department
4. Surgery, Anesthesiology, OR, PACU, & Critical Care
5. Diagnostic & Blood Services
6. Other Patient Care Services
7. Diversion & Interfacility Transfer
8. Trauma Registry
9. Quality Improvement
10. Outreach & Education

Trauma Service Administration

Standards of Care

A designated **Level III** trauma service must have:

1. A written scope of trauma service for both adult and pediatric trauma patients consistent with chapter 246-976 WAC, community needs and the approved regional plan. The written scope of trauma service must delineate the resources and capabilities available for trauma patient care twenty-four hours, every day;
2. A trauma service director responsible for organization and direction of the trauma service. The director must be a general surgeon with special competence in care of the injured. The director may delegate duties to another surgeon, but the director must maintain responsibility for the trauma service;
3. A trauma service coordinator responsible for ongoing coordination of the trauma service. The coordinator must be a registered nurse with special competence in the care of the injured;
4. A multidisciplinary trauma committee chaired by the trauma service director with membership that reflects your written scope of trauma service. The multidisciplinary committee must have responsibility and authority for establishing and changing trauma care policy and procedure and for conducting the trauma service quality improvement program in accordance with WAC 246-976-881, see *Exhibit A*.

Assurance

☐ Meets the above standards of care. ☐ Does not meet the above standards of care.
If not, list the standard(s) not being met and explain how the service will be brought into compliance, include a completion date.

Documentation

1. Highlight any significant accomplishments or changes to the trauma service that have occurred over the last designation cycle.
2. Explain the implementation of the final report requirements and review team recommendations from the previous designation cycle. (Describe what was successful, what was not, and still needs improvement.)
3. Describe how Trauma Participation Grants received during the last designation cycle were used to support your trauma service. (If you had any unique purchases, projects, or training opportunities that could serve as an example to other services throughout our trauma system; provide a description so that it can be added to a "best practices" resource guide for Trauma Coordinators throughout the state.)
4. Provide the hospital organizational chart. The chart must show how the trauma service, including the multidisciplinary trauma committee, fits into the organizational structure. Explain the communication or reporting structure.
5. List the multidisciplinary trauma committee members, include:
   a. Name, credentials, and medical specialty;
   b. Title;
   c. Department or service represented; and
   d. Attendance for year June 2004 through May 2005.
   (If poor attendance is an issue, explain how it is addressed by the committee.)
6. Provide a description of your multidisciplinary trauma committee, include its:
   a. Function;
   b. Responsibility; and
   c. Authority
7. The revised designation rules require that the Trauma Service (Medical) Director (TSD) be a general surgeon. The general surgeon is allowed to delegate duties. If your TSD delegates trauma service duties, please list who those duties are delegated to; include the name, title, specialty and the duties delegated.

Trauma Team Activation

Standards of Care

A designated **Level III** trauma service must have:

1. A full trauma team to provide initial evaluation, resuscitation, and treatment. The full trauma team must include:
   a. A general surgeon with special competence in care of the injured, who organizes and directs the team and assumes responsibility for coordination of overall care of the trauma patient. The surgeon must be at least a postgraduate year four resident;
   b. An emergency physician who is responsible for providing team leadership and care for the trauma patient until the arrival of the general surgeon in the resuscitation area; and
   c. The trauma service must identify all other members of the team to reflect your written scope of trauma service.
2. A method for activating its full trauma team. The method must:
   a. Be based on patient information obtained from prehospital providers and other sources appropriate to the circumstances;
   b. Include mandatory presence of the general surgeon. The surgeon must be at least a postgraduate year four;
   c. Specify patient criteria for determining mandatory activation of the full trauma team;
   d. Be applied regardless of time post injury or previous care, whether delivered by EMS or other means, and whether transferred from the scene or from another hospital;
   e. The method for activation of the full trauma team may include response by a neurosurgeon instead of a general surgeon when, based on prehospital information, the mechanism of injury clearly indicates isolated penetrating trauma to the brain; and
   f. The trauma service must adopt a trauma quality improvement audit filter to monitor the appropriateness of and compliance with the full trauma team activation criteria.

A designated **Level III** trauma service may have:

1. A method for activating a modified trauma team. The method must:
   a. Specify patient criteria for determining activation of the modified trauma team;
   b. Include a mechanism to upgrade the level of trauma team response to full based on newly acquired information; and
   c. The trauma service must adopt a trauma quality improvement audit filter to monitor the appropriateness of and compliance with your modified trauma team activation criteria.

Assurance
☐ Meets the above standards of care. ☐ Does not meet the above standards of care. If not, list the standard(s) not being met and explain how the service will be brought into compliance, include a completion date.
Documentation
1. Submit your methodology for full trauma team activation (TTA). (DOH's definition of a full TTA is, "when resources are mobilized for an automatic response, including the general surgeon.") Include: a. Patient physiologic and/or anatomical injury criteria for a full team activation; b. A list of full team members that are required to respond automatically; and c. An activation tool/form used to identify trauma patients needing team activation.
2. Submit your methodology for modified trauma team activation (if used), and include: a. Patient physiologic and/or anatomical injury criteria for a modified team activation; b. A list of modified team members that are required to respond automatically; and c. The procedure used to upgrade a patient to a full activation, when warranted.
3. Describe the results of your TTA (over and under triage) quality improvement (QI) review, or conduct a retrospective review (calendar year 2004), and describe the results including the following information: a. The audit filter(s) used; b. The specific QI steps used to evaluate activations and inappropriate non-activations; c. Any actions taken to improve trauma team activation compliance or the process; d. The conclusions of your QI review; and e. Any follow-up actions taken or still needed.

Emergency Department

Standards of Care

A designated **Level III** trauma service must have:

1. An emergency department, including:
   a. Emergency department equipment for resuscitation and life support of pediatric and adult trauma patients, including equipment described in WAC 246-976-620, see *Exhibit A*;
   b. An area designated for adult and pediatric resuscitation;
   c. Written standards of care to ensure immediate and appropriate care for adult and pediatric trauma patients;
   d. A physician director, who:
      i. Is board-certified in emergency medicine, surgery, or other relevant specialty;
      ii. Is ATLS and ACLS trained, except this requirement does not apply to a physician board-certified in emergency medicine or surgery;
      iii. Has completed the pediatric education requirement (PER) as defined in WAC 246-976-886, see *Exhibit A*, except that this requirement does not apply to a physician board-certified in pediatric emergency medicine;
   e. Physicians, who:
      i. Have special competence in resuscitation, care, and treatment of trauma patients;
      ii. Are available within five minutes of patient's arrival in the emergency department;
      iii. Are ATLS and ACLS trained, except this requirement does not apply to a physician board-certified in emergency medicine; and
      iv. Have completed the PER as defined in WAC 246-976-886, except this requirement does not apply to a physician board-certified in pediatric emergency medicine;
   f. Registered nurses who:
      i. Are in the emergency department and available within five minutes of patient's arrival;
      ii. Are ACLS trained;
      iii. Have completed the PER as defined in WAC 246-976-886; and
      iv. Have successfully completed a trauma life support course as defined in WAC 246-976-885, see *Exhibit A*.

Assurance

☐ Meets the above standards of care. ☐ Does not meet the above standards of care.
If not, list the standard(s) not being met and explain how the service will be brought into compliance, include a completion date.

Documentation

1. Describe your service's experience developing a standard of trauma care, trauma clinical guideline, or standardized admission order that was successfully implemented in 2004-2005. Provide the document and include:
   a. Problem identification;
   b. Priority;
   c. Resources (literature and personnel);
   d. Education;
   e. Implementation; and
   f. Evaluation.

(Examples: C-spine clearance policy, standing orders, ETOH screening and intervention, pain management.)
(Do not use trauma team activation.)

Surgery, Anesthesiology, OR, PACU, & Critical Care

Standards of Care

A designated **Level III** trauma service must have:

1. **General surgery services**, with:
   a. An attending general surgeon, on-call and available within thirty minutes of notification of team activation; and
   b. All general surgeons who are responsible for care and treatment of trauma patients must:
      i. Be trained in ATLS and ACLS, except this requirement does not apply to a physician board-certified in surgery;
      ii. Have completed the PER as defined in WAC 246-976-886, see *Exhibit A*; and
      iii. Have specific delineation of trauma surgery privileges by the medical staff.
2. The ability to resuscitate and stabilize acute head and/or spinal cord injuries.
3. **A neurosurgeon, on-call** and available within thirty minutes of team leader's request **or** written transfer guidelines and agreements for head and spinal cord injuries.
4. **Obstetric surgery services, on-call** and available within thirty minutes, as requested by the trauma team leader, **or** a plan to manage the pregnant trauma patient.
5. **Orthopedic surgery services, on-call** for patient consultation or management.
6. **Anesthesiology**, with:
   a. An anesthesiologist **or** certified registered nurse anesthetist, on-call and available within thirty minutes of team leader's request, who:
      i. Is ACLS trained, except this requirement does not apply to a physician board-certified in anesthesiology; and
      ii. Has completed the pediatric education requirement (PER) as defined in WAC 246-976-886.
7. **An operating room**, with:
   a. A registered nurse or designee, available within five minutes of notification of team activation, to open and prepare the operating room;
   b. Other essential personnel, as identified by the trauma service, on-call and available within thirty minutes of notification of team activation;
   c. A written policy providing for mobilization of additional surgical teams for trauma patients; and
   d. Instruments and equipment appropriate for pediatric and adult surgery, including equipment described in WAC 246-976-620, see *Exhibit A*.
8. **A post anesthetic recovery service**, with:
   a. At least one registered nurse, on-call and available twenty-four hours a day;
   b. Nurses ACLS trained; and
   c. Nurses who have completed the PER as defined in WAC 246-976-886.
9. **A critical care service**, with:
   a. A medical director, who:
      i. Is board-certified in surgery, internal medicine, or anesthesiology, with special competence in critical care; and
      ii. Responsible for coordinating with the attending staff for the care of trauma patients.
   b. A physician directed code team;
   c. Critical care registered nurses, with special competence in trauma care, who:
      i. Are ACLS trained; and
      ii. Have successfully completed a trauma life support course as defined in WAC 246-976-885, see *Exhibit A*.
   d. Designation as a pediatric trauma service **or** written transfer guidelines and agreements for pediatric trauma patients requiring critical care services; and
   e. Critical care equipment as described in WAC 246-976-620.

Assurance

☐ Meets the above standards of care. ☐ Does not meet the above standards of care.
If not, list the standard(s) not being met and explain how the service will be brought into compliance, include a completion date.

Documentation
1. Provide the criteria (in a policy or narrative format) used to determine when a trauma patient is admitted to the general surgeon, versus a surgical sub specialist or non-surgeon.
2. Describe the process used to determine when a trauma patient is transferred from a general surgeon's care to a surgical sub specialist or non-surgeon's care. Include any written standard of care or policy.
3. Provide a narrative description of how an operating room is made available for trauma during peak surgery times, and after hours.
4. Provide a narrative description of how a room is made available in the Critical Care Unit for trauma patients when the unit is full.

Diagnostic and Blood Services

Standards of Care

A designated **Level III** trauma service must have:

1. Radiological services, with:
   a. A radiologist, on-call and available within thirty minutes of team leader's request;
   b. A technician able to perform routine radiological capabilities, on-call and available within twenty minutes of notification of team activation; and
   c. A technician able to perform computerized tomography, on-call and available within twenty minutes of team leader's request.
2. Clinical laboratory services, including:
   a. A clinical laboratory technologist, available within five minutes of notification of team activation;
   b. Standard analysis of blood, urine, and other body fluids;
   c. Coagulation studies;
   d. Blood gases and pH determination;
   e. Microbiology;
   f. Serum alcohol determination; and
   g. Drug or toxicology screening.
3. Blood and blood-component services, including:
   a. Blood and blood components available from in-house or through community services, to meet patient needs;
   b. Noncrossmatched blood, available on patient arrival in the emergency department;
   c. Ability to obtain blood typing and crossmatching;
   d. Policies and procedures for massive transfusion;
   e. Autotransfusion; and
   f. Blood storage capability.

Assurance

☐ Meets the above standards of care. ☐ Does not meet the above standards of care.
If not, list the standard(s) not being met and explain how the service will be brought into compliance, include a completion date.

Documentation

1. Describe your trauma service's diagnostic imaging methods—including tele-radiology, and CT. Describe for each:
   a. How the method is selected and prioritized for trauma patients;
   b. Any evaluation of trauma patient access to these methods (what's working and what isn't); and
   c. How discrepant imaging readings are identified, monitored, resolved, and followed-up, with timelines and any remaining barriers.
2. Provide your trauma lab panel, if used; or indicate if your service does not use a lab panel.
3. Describe the process for obtaining blood specimens, testing, and providing blood products (universal donor, type-specific, and cross-matched) to the trauma patient. Include field-drawn specimens, if used. Include:
   a. The turn-around time for each product;
   b. A description of how the product is selected and prioritized for trauma patients;
   c. Describe any evaluation and results of blood product accessibility for trauma patients (what's working and what isn't); and
   d. Indicate how accessibility problems are monitored, identified, and resolved, with timelines and any remaining barriers.

Other Patient Care Services

Standards of Care

A designated **Level III** trauma service must have:

1. Respiratory therapy, on-call and available within thirty minutes of notification of team activation.
2. Acute dialysis capability, **or** written transfer agreements for dialysis services.
3. The following services, on-call and available for patient consultation or management during the in-patient stay:
   a. Internal medicine; and
   b. Pathology.
4. Written policies and procedures for access to ancillary services for in-patient care, including:
   a. Chemical dependency services;
   b. Child and adult protection services;
   c. Clergy or pastoral care;
   d. Nutritionist services;
   e. Pharmacy services;
   f. Occupational therapy services;
   g. Physical therapy services;
   h. Speech therapy services;
   i. Social services; and
   j. Psychological services.
5. The ability to resuscitate and stabilize burn patients.
6. A physician directed burn unit staffed by nursing personnel trained in burn care and equipped to care for extensively burned patients; **or** written transfer guidelines and agreements in accordance with the guidelines of the American Burn Association.
7. A trauma rehabilitation coordinator to facilitate the trauma patient's access to rehabilitation services.
8. A designated trauma rehabilitation service; **or** written agreements to transfer patients to a designated trauma rehabilitation service when medically feasible.

Assurance

☐ Meets the above standards of care. ☐ Does not meet the above standards of care.
If not, list the standard(s) not being met and explain how the service will be brought into compliance, include a completion date.

Documentation

1. Indicate whether trauma patients are consistently tested for blood alcohol levels and urine toxicology.
   a. Provide any policy that indicates a screening requirement;
   b. Describe the process to refer trauma patients who test positive; and
   c. Include the documentation tool, if used.
2. Describe the process to screen and refer major trauma patients to inpatient and/or outpatient (physical) rehabilitation services.

Diversion & Interfacility Transfer

Standards of Care

A designated **Level III** trauma service must have:

1. A written policy and procedures to divert patients to other designated trauma care services when the facility's resources are temporarily unavailable for trauma patient care. The policy must include:
   a. The facility and/or patient criteria used to decide when to divert a trauma patient;
   b. A process to coordinate trauma patient diversions with other area trauma services and prehospital agencies; and
   c. A method for documenting trauma patient diversions, including: Date, time, duration, reason, and decision maker.
2. Interfacility transfer guidelines and agreements consistent with your written scope of trauma service and consistent with WAC 246-976-890, see *Exhibit A*.
3. A heli-stop, landing zone or airport located close enough to permit the facility to receive or transfer patients by fixed-wing or rotary-wing aircraft.

Assurance

☐ Meets the above standards of care. ☐ Does not meet the above standards of care.
If not, list the standard(s) not being met and explain how the service will be brought into compliance, include a completion date.

Documentation

1. Describe how your service diverts trauma patients, include:
   a. Whether you actually go on divert for trauma;
   b. What your plan is when on divert;
   c. Whether you track trauma diversions; and
   d. Whether diversions are physician directed.
2. If you divert, and tracking information is available, provide the number of trauma patient diversions from your service for June 2004 through May 2005, and the reason(s) for each divert.
3. Provide your transfer criteria that clearly defines those patients with special trauma care needs exceeding the capabilities of your trauma service. Include pediatric transfer criteria. (Transfer criteria should be consistent with your scope of trauma service.)
4. Provide your admission criteria for trauma patients and include the admitting physician specialty. (The scope of trauma service should reflect those capabilities.)
5. Provide a list from your trauma registry of all hospitals receiving acute trauma patients from your service (not rehab patients).

Trauma Registry

Standards of Care

A designated **Level III** trauma service must:

1. Participate in the state trauma registry as required in WAC 246-976-430, see *Exhibit A*.
2. Have a person identified as responsible for coordination of trauma registry activities.
3. Collect patient data for patients who meet the inclusion criteria identified in WAC 246-976-430.
4. Submit required data via electronic transfer. Data must be submitted no later than 90 days after the end of each quarter.

Assurance

☐ Meets the above standards of care. ☐ Does not meet the above standards of care.
If not, list the standard(s) not being met and explain how the service will be brought into compliance, include a completion date.

Documentation

1. Getting run sheets from all participating EMS agencies has been recognized as a problem around the state. Describe what you are doing to improve prehospital completion and timely submission of run sheets to your service, e.g., letters to EMS agencies; follow-up calls; access to their database; follow-up debriefings; etc. Include the barriers you have had to overcome and any recognized as a current problem.
2. Explain how trauma registry problems/issues are identified and addressed, especially late or insufficient data submissions, e.g., data not submitted by DOH's deadline; duplicate records; missing or incorrect data; data not being captured and therefore entered as "unknown" or "inappropriate;" etc.
3. Describe the process of assigning injury codes to your trauma registry cases. Include:
   a. If you type in injury diagnoses (text) from the chart into Collector trauma registry software;
   b. If you type in ICD-9 codes into Collector. If so, indicate who originally assigns the ICD-9 codes to the chart;
   c. If you "hand code" the chart by using the Abbreviated Injury Scale (AIS) book, or the Washington State Trauma Coding Course Book, then enter the relevant injury diagnoses into Collector;
   d. How you calculate the Injury Severity Score (ISS)--by hand, or do you use Collector software; and
   e. The processes you use to resolve injury coding questions in your trauma service. Include any contact with hospital coders, physicians, etc.
4. Indicate whether your registrar attended an AIS or Washington State Trauma Coding Course over the last designation cycle.

Quality Improvement Program

Standards of Care

A designated **Level III** trauma service must have:

1. A quality assessment and improvement program conducted by the multidisciplinary trauma committee that reflects and demonstrates a process for continuous quality improvement consistent with the written scope of trauma service, with:
   a. An organizational structure that facilitates the process of quality assurance and improvement and identifies the authority to change policies, procedures, and protocols that address the care of the trauma patient;
   b. Developments of standards of quality care;
   c. A process for monitoring compliance with or adherence to the standards;
   d. A process of peer review to evaluate specific cases or problems identified by the monitoring process;
   e. A process for correcting problems or deficiencies;
   f. A process to analyze and evaluate the effect of corrective action; and
   g. A process to insure that confidentiality of patient and provider information is maintained according to the standards of RCW 70.41.200 and 70.168.090.
2. Participation in the regional quality assurance program in accordance with WAC 246-976-910, *Exhibit A.*

Assurance

☐ Meets the above standards of care. ☐ Does not meet the above standards of care.
If not, list the standard(s) not being met and explain how the service will be brought into compliance, include a completion date.

Documentation

1. Submit your formal trauma quality improvement policy/plan. It must include and explain at a minimum:
   a. A defined population of patients to be monitored;
   b. All trauma quality indicators and/or audit filters used in the previous designation cycle;
   c. The frequency and process of quality review;
   d. Trauma Service (Medical) Director and other physician involvement (peer review);
   e. List any trauma standards of care, policies, or protocols that have been generated from your trauma QI program during the previous designation cycle; and
   f. Loop closure and resolution.
2. Describe how cases are identified and then reviewed through the QI program, include:
   a. Physician issues;
   b. Nursing issues;
   c. System issues; and
   d. Prehospital issues.
3. Describe how the Trauma Service (Medical) Director assures that patient care and QI processes for trauma patients admitted to specialty services are consistent with trauma service expectations.
4. Provide a summary of your quality indicator/audit filter analysis during the previous designation cycle. DOH is interested in what filters you have developed (not ACS or JACHO filters in Collector) to address the specific issues concerning your trauma service, e.g., air transport utilization; time to CT; time to OR; geriatric care management; etc. *Mark as confidential.*
5. Provide a quality summary of one significant trauma filter result or issue for **each** category listed below. (Remove ALL patient and practitioner identifiers. *Mark as confidential*.) The cases must be real, not hypothetical. Include the issue, conclusions, recommendations, action plans from all committees, and the evaluation/loop closure for **each** of the following categories:
   a. A system issue, involving more than one entity in either a hospital or out-of-hospital setting. (Do not use trauma team activation as your system issue.);
   b. A physician practice issue; and
   c. A death case review from your service. Include results of any regional QI review discussion.
6. A list of the regional QI meetings for the previous year, indicate those the TSD and TSC attended. Include whether your service presented any cases or issues for regional review, and indicate whether it was presented for learning purposes, or to resolve a system or regional issue.

Outreach & Education

Standards of Care
A designated **Level III** trauma service must: 1. Have a public education program addressing injury prevention or documentation of participation in regional injury prevention activities. 2. Make the facility available for initial and maintenance training of invasive manipulative skills for prehospital personnel.
Assurance
☐ Meets the above standards of care. ☐ Does not meet the above standards of care. If not, list the standard(s) not being met and explain how the service will be brought into compliance, include a completion date.
Documentation
1. List the public injury prevention education conducted by your trauma service over the last designation cycle. Describe how data was used to select and monitor injury prevention activities.
2. Indicate whether the top three mechanisms of injury from the last designation cycle are still the top three, and describe future public injury prevention education planned for the next 3 years, include: a. Who will be conducting the education; b. Funding resources; and c. List any local or regional partnerships (present or future) developed to accomplish education goals for the next designation period.
3. Although provider education is not a WAC requirement for Level III Trauma Services, please list any provider education (EMS, community physicians, trauma service staff) that you developed or sponsored over the last designation cycle. Include any partnerships with other services or organizations for each educational activity.
4. Provide the number of prehospital personnel that have utilized your hospital for initial and maintenance training of invasive manipulative skills. Explain any barriers that you have had to overcome since the last designation cycle, or any future barriers you foresee, in being able to provide access for this training.
5. Describe your process for providing individual patient follow-up information to all trauma services that transfer trauma patients to your service.
6. Describe your process for monitoring, identifying, communicating, and intervening on care or system issues with an individual sending service and provider (other than routine discharge summaries). Include individual outreach, consultation, and education. Also describe your process for communicating exemplary care to sending services and providers.
7. Describe your process to provide feedback to prehospital providers and the EMS Medical Program Director regarding trauma patients transported to your service.

STAFF RESOURCE LIST WITH EDUCATION & TRAINING

1. For each provider group, describe the methods your hospital uses to ensure that the Pediatric Education Requirements (PER) have been met. The PER Implementation Plan distributed in May 2002, indicated that, "enforcement and compliance will be measured beginning May 2004 at the beginning of the next designation period. The department will use the trauma designation application for documentation of provider's specialties and education to ensure that these PER and other standards are met."

2. Provide the hospital's definition for "special competence in resuscitation, care, and treatment of adult trauma patients," as it relates to emergency department physicians.

3. All staff must meet the education and training requirements outlined in WAC 246-976-535. The intent of the 90% rule, WAC 246-976-885, is to allow for the fluctuation in staffing levels. Include a compliance plan for any personnel that have not achieved the education and training requirements (e.g., 15% of the emergency physicians have not had ACLS training, etc.)

4. ATLS, ACLS, and PALS currency is not required. Medical staff must have taken the courses once during their career to meet DOH standards.

To complete the following tables electronically, just click on the shaded rectangle and type your responses. You can tab through the document to move from one field to the next. To "activate" or mark a checkbox, just point your curser and click in the checkbox you want to "activate." To "deactivate" it, just re-click the checkbox. If you need to adjust the tables to add rows, call Sandi Shaw at 360-236-2871, for instructions, ***before inputting data****.*

EMERGENCY DEPARTMENT									
ED Director	Board certified emergency medicine, surgery, or relevant specialty			ACLS❖ training achieved		ATLS❖ training achieved		Completed PER⊕	
	☐Yes ☐No Specialty:			☐Yes ☐No		☐Yes ☐No		☐Yes ☐No	
ED Physicians	Board certified			ACLS❖ training achieved		ATLS❖ training achieved		Completed PER⊕	
	Yes	No	Specialty:	Yes	No	Yes	No	Yes	No
	☐	☐		☐	☐	☐	☐	☐	☐
	☐	☐		☐	☐	☐	☐	☐	☐
	☐	☐		☐	☐	☐	☐	☐	☐
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	☐	☐		☐	☐	☐	☐	☐	☐
	☐	☐		☐	☐	☐	☐	☐	☐
	☐	☐		☐	☐	☐	☐	☐	☐
The percentage of Registered Nurses that have met the ACLS training requirement									
The percentage of Registered Nurses that have met the PER requirement									
The percentage of Registered Nurses that have met the Trauma training■ requirement									

❖ ACLS & ATLS training not required if board certified in emergency medicine or surgery.
⊕ PER not required if board certified in pediatric emergency medicine.
■ See *Exhibit A* for WAC 246-976-885.

SURGERY SERVICE						
List the attending surgeons board certified in General Surgery	Completed PER					
	Yes			No		
	☐			☐		
	☐			☐		
	☐			☐		
	☐			☐		
	☐			☐		
	☐			☐		
	☐			☐		
	☐			☐		
	☐			☐		
	☐			☐		
List the non board certified General Surgeons	ACLS training achieved		ATLS training achieved		Completed PER	
	Yes	No	Yes	No	Yes	No
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐

NEUROSURGICAL SERVICE (If provided as part of scope of trauma service)	
List the number of board certified Neurosurgeons	
List the number of non board certified Neurosurgeons	

ANESTHESIOLOGY SERVICE				
List the Anesthesiologists board certified in Anesthesiology	Completed PER			
	Yes		No	
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	
	☐		☐	
List the non board certified Anesthesiologists	ACLS training achieved		Completed PER	
	Yes	No	Yes	No
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
List the Certified Registered Nurse Anesthetists	ACLS training achieved		Completed PER	
	Yes	No	Yes	No
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

Board certification in anesthesiology not required.

POST ANESTHETIC RECOVERY SERVICE	
The percentage of Registered Nurses who have met the ACLS requirement	
The percentage of Registered Nurses that have met the PER requirement	

CRITICAL CARE SERVICE			
Medical Director	Board certified surgery, internal medicine, or anesthesiology with special competence in critical care	Specialty	
	☐Yes ☐No		
The percentage of Registered Nurses that have met the ACLS training requirement			
The percentage of Registered Nurses that have met the trauma training▪ requirement			

▪ See *Exhibit A* for WAC 246-976-885.

SCOPE OF TRAUMA SERVICE

The purpose of the written Scope of Trauma Service is to identify the minimum level of resources available for trauma patient care at your hospital on a 24 hour per day, seven days per week (24/7) basis. Some of the questions below will address resource minimum standards for Level III. These are the resources that **must** be available 24/7. Some questions will address resources above the minimum standard for Level III. These resources may or may not be available 24/7 at your hospital for trauma patient care. (*This is an electronic form. Once again, you can progress through these questions by using the tab key. Click the checkboxes to activate them. Also click on the gray rectangles (text boxes) to type your other responses. The text box will expand and wrap to allow you space for your answers*.)

Emergency Department (ED)

Minimum Standard: A Level III trauma service must have physicians with special competence in resuscitation, care and treatment of trauma patients, available within 5 minutes of patient arrival.

1. Are all ED physicians board-certified in emergency medicine? ☐Yes ☐No
   a. If yes, indicate how many are on staff. _____
   b. If no, indicate what specialty the ED physicians have:

	number on staff	number board certified
☐ Emergency Medicine	_____	_____
☐ Internal Medicine	_____	_____
☐ Family Practice	_____	_____
☐ General Surgery	_____	_____
☐ Other (list): _____	_____	_____

Radiology Services

Minimum Standard: A radiologist on-call and available within 30 minutes of team leader's request; a technician able to perform routine radiological capabilities on-call and available within 20 minutes of notification of team activation; a technician able to perform computerized tomography on-call and available within 20 minutes of team leader's request.

1. Describe the typical radiological services available for trauma patients (ex. plain films, ultrasound, CT, MRI). _____

Surgery Department

Minimum Standard: A Level III trauma service must have a general surgeon on call and available within 30 minutes of notification of team activation.

1. How many general surgeons take trauma call? _____
2. Do the surgeons take call at other hospitals? ☐Yes ☐No
   a. If yes, does your trauma service call schedule ensure that the general surgeon is not on call simultaneously at a second hospital? ☐Yes ☐No
3. List the typical general surgery procedures performed for trauma patients at your hospital and the typical general surgery procedures transferred to a higher level trauma service. _____

Orthopedic Surgery

Minimum Standard: A Level III must have orthopedic surgery on call and available for patient consultation or management.

1. Are orthopedic surgeons on-call and available within 30 minutes? ☐Yes ☐No
   a. If yes, how many orthopedic surgeons are available for trauma call? _____
   b. If no, how many orthopedic surgeons are on-call for patient consultation or management? _____
2. Describe how orthopedic surgeons are involved in the care of trauma patients at your hospital. _____
3. List the typical orthopedic procedures performed for trauma patients and the typical orthopedic injuries transferred to a higher level trauma service. _____

Neurosurgery

Minimum Standard: A Level III trauma service must have a neurosurgeon on-call and available within thirty minutes of team leader's request OR written transfer guidelines and agreements for head and spinal cord injuries.

1. Are neurosurgery services available for trauma patient care 24/7? ☐Yes ☐No
2. How many neurosurgeons take trauma call? _____
3. List the typical neurosurgery procedures performed for trauma patients and the typical neurosurgery procedures transferred to a higher level trauma service. _____

Anesthesia Services

1. Indicate the level of anesthesia provider available for trauma patients 24/7:

	number on staff
☐ Anesthesiologist	_____
☐ Certified Registered Nurse Anesthetist	_____

Other Surgery Services

1. Indicate whether the following surgical services are available 24/7 for trauma patients:

☐ Obstetric surgery	☐ Gynecologic surgery
☐ Thoracic surgery	☐ Ophthalmic surgery
☐ Urologic surgery	☐ Oral/maxillofacial or ENT surgery
☐ Vascular surgery	☐Plastic surgery

2. Is a second OR crew available 24/7? ☐Yes ☐No

Critical Care Services

Minimum Standard: A Level III trauma service must have a critical care service.

1. Describe the critical care services available for trauma patients (address acute hemodialysis, intracranial pressure monitoring, cardiac output monitoring, mechanical ventilation.). _____

Trauma Registry Reports

Run trauma registry reports as outlined in the "Registry Report Writing Guidelines" (separate pdf document). The reports are intended to assist DOH and the reviewers in preparation for the site review. After running your reports, review them for quality and completeness. (You may want to clean up the data before submitting your reports.)

Provide a brief narrative interpretation of each registry report, explaining any unusual circumstances or conditions that would be of interest to the reviewers, and identify any cases that appear to be inconsistent with your hospital's scope of trauma service or internal policies. Include whether your quality improvement committee reviewed these cases, and if so, the actions taken. **Explicitly follow the report writing guidelines**, so all queries and reports are consistent and accurate. Call the DOH registry help-line (Marc Tafoya) at 800-458-5281, ext. 4, for any problems preparing reports.

Create a tab page labeled "Registry Reports," insert your narrative interpretation, and then the reports at the end of your completed application. Mark all registry reports, narratives, explanations, and QI notations as confidential.

Provide the following data table reports:

1. Trauma Team Activation Report
   Records with Scene or ED SBP < 90 or HR Scene ED > 120

2. Pediatric Care Report
   Records with age < 15 years, ISS > 9 who were admitted

3. Delayed Transfers Report
   Records with ISS ≥ 9, who were admitted, then transferred to another acute care facility

4. Transfer of Minor Injuries Report
   Records with ISS < 9 and transferred from the ED to another acute care facility

5. ED LOS > 3 Hours Report
   Records with ISS ≥ 16 and ED LOS > 3 hours.

6. OR Report
   Records with ISS ≥ 16 and ED disposition to the OR and surgeon response time > 20 minutes or unknown

7. Geriatric Trauma Report
   Records with age ≥ 65 with an ISS ≥ 16 who were admitted

EXHIBITS

Exhibit A

Referenced Designation WAC's

WAC 246-976-430
Trauma registry - Provider responsibilities

1. Trauma care providers, prehospital and hospital, must place a trauma ID band on trauma patients, if not already in place from another agency.
2. All trauma care providers must protect the confidentiality of data in their possession and as it is transferred to the department.
3. All trauma care providers must correct and resubmit records which fail the department's validity tests described in WAC 246-976-420(6). You must send corrected records to the department within three months of notification.
4. Licensed prehospital services that transport trauma patients must:
   a. Assure personnel use the trauma ID band.
   b. Report data as shown in Table E for trauma patients defined in WAC 246-976-420. Data is to be reported to the receiving facility in an approved format within ten days.
5. Designated trauma services must:
   a. Assure personnel use the trauma ID band.
   b. Report data elements shown in Table F for all patients defined in WAC 246-976-420.
   c. Report patients discharged in a calendar quarter in an approved format by the end of the following quarter. The department encourages more frequent data reporting.

WAC 246-976-620
Equipment Standards for Trauma Service Designation

A facility with a designated trauma service must:	LEVELS							
	I	IP	II	IIP	III	IIIP	IV	V
1. Have the following equipment, both adult and pediatric sizes in the emergency department (or resuscitation area for level V):	X	X	X	X	X	X	X	X
a. Airway control and ventilation equipment, including:	X	X	X	X	X	X	X	X
i. Airways;	X	X	X	X	X	X	X	X
ii. Laryngoscopes, including curved and straight blades;	X	X	X	X	X	X	X	X
iii. Endotracheal tubes, with stylets available;	X	X	X	X	X	X	X	X
iv. Bag-valve-mask resuscitator;	X	X	X	X	X	X	X	X
v. Pulse oximeter;	X	X	X	X	X	X	X	X
vi. CO_2 measurement;	X	X	X	X	X	X	X	X
vii. Sources of oxygen;	X	X	X	X	X	X	X	X
viii. Ability to provide mechanical ventilation;	X	X	X	X	X	X		
b. Suction devices, including:	X	X	X	X	X	X		
i. Back-up suction source;	X	X	X	X	X	X	X	X
ii. Suction catheters;	X	X	X	X	X	X	X	X
iii. Tonsil tip suction (except level V clinics);	X	X	X	X	X	X	X	X
c. Cardiac devices, including:	X	X	X	X	X	X	X	X
i. Cardiac monitor;	X	X	X	X	X	X	X	X
ii. Defibrillator;	X	X	X	X	X	X	X	X
iii. Electrocardiograph;	X	X	X	X	X	X	X	X
iv. Portable cardiac monitor;	X	X	X	X	X	X	X	X
v. Blood pressure cuffs;	X	X	X	X	X	X	X	X
vi. Doppler device;	X	X	X	X	X	X	X	
d. Intravenous supplies, including:	X	X	X	X	X	X	X	X
i. Standard intravenous fluids and administering devices, including:	X	X	X	X	X	X	X	X
A. IV access devices;	X	X	X	X	X	X	X	X
B. Intraosseous needles;	X	X	X	X	X	X	X	X
C. Infusion control device;	X	X	X	X	X	X	X	X
ii. Drugs & supplies necessary for adult & pediatric emergency care;	X	X	X	X	X	X	X	X
e. Sterile surgical sets for standard emergency department procedures, including:	X	X	X	X	X	X	X	X
i. Thoracotomy set;	X	X	X	X	X	X	X	
ii. Chest tubes with closed drainage devices (except level V clinics);	X	X	X	X	X	X	X	X
iii. Emergency transcutaneous airway set (except level V clinics);	X	X	X	X	X	X	X	X
iv. Peritoneal lavage set;	X	X	X	X	X	X		
f. Nasogastric tubes (except level V clinics);	X	X	X	X	X	X	X	X

WAC 246-976-620
Equipment Standards for Trauma Service Designation (continued)

A facility with a designated trauma service must:	LEVELS							
	I	IP	II	IIP	III	IIIP	IV	V
g. Ability to provide thermal control equipment, including:	X	X	X	X	X	X	X	X
i. Patient warming capability (except level V clinics);	X	X	X	X	X	X	X	X
ii. Blood and fluid warming capability (except level V clinics);	X	X	X	X	X	X	X	X
iii. Expanded scale thermometer capable of detecting hypothermia (except level V clinics);	X	X	X	X	X	X	X	X
h. Immobilization devices, including:	X	X	X	X	X	X	X	X
i. Cervical injury immobilization devices;	X	X	X	X	X	X	X	X
ii. Long-bone immobilization devices, including traction splints; and	X	X	X	X	X	X	X	X
iii. Backboard;	X	X	X	X	X	X	X	X
i. Other equipment:	X	X	X	X	X	X	X	X
i. Urinary bladder catheters (except level V clinics);	X	X	X	X	X	X	X	X
ii. Infant scale for accurate weight measurement under twenty-five pounds;	X	X	X	X	X	X	X	X
iii. Medication chart, tape, or other system to assure ready access to information on proper doses-per-kilogram for resuscitation drugs and equipment sizes for pediatric patients;	X	X	X	X	X	X	X	X
iv. Two-way radio linked with EMS/TC vehicles;	X	X	X	X	X	X	X	X
2. Have the following equipment, both adult and pediatric sizes, in the surgery department:	X	X	X	X	X	X	X	
a. Cardiopulmonary bypass;	X	X						
b. Ability to provide thermal control equipment for:	X	X	X	X	X	X	X	
i. Patient warming and cooling;	X	X	X	X	X	X	X	
ii. Blood and fluid warming;	X	X	X	X	X	X	X	
c. Rapid infusion capability;	X	X	X	X	X	X	X	
d. Autologous blood recovery and transfusion;	X	X	X	X	X	X		
e. Ability to provide bronchoscopic capability in the operating room;	X	X	X	X	X	X		
f. Ability to provide endoscopes;	X	X	X	X	X	X	X	
g. Craniotomy set;	X	X	X	X				
3. Have the following equipment, both adult and pediatric sizes, in the critical care unit:								
4. ***NOTE for level III pediatric: If your written scope of trauma service includes critical care services, then your service must meet the level II pediatric critical care equipment standards.***						X		
5. ***NOTE for level IV: If your written scope of trauma service includes critical care services, then your service must meet the level III critical care equipment standards.***							X	

WAC 246-976-620
Equipment Standards for Trauma Service Designation (continued)

A facility with a designated trauma service must:	LEVELS							
	I	IP	II	IIP	III	IIIP	IV	V
a. Airway control and ventilation devices, including:	X	X	X	X	X			
i. Oral and nasopharyngeal airways;	X	X	X	X	X			
ii. Laryngoscopes with curved and straight blades;	X	X	X	X	X			
iii. Endotracheal tubes with stylets available;	X	X	X	X	X			
iv. Bag-valve-mask resuscitators;	X	X	X	X	X			
v. Ability to provide mechanical ventilator;	X	X	X	X	X			
vi. Noninvasive oximetry and capnometry;	X	X	X	X	X			
vii. Oxygen source with concentration controls;	X	X	X	X	X			
b. Suction devices, including:	X	X	X	X	X			
i. Suction machine;	X	X	X	X	X			
ii. Suction catheters;	X	X	X	X	X			
iii. Tonsil tip suction;	X	X	X	X	X			
c. Cardiac devices, including:	X	X	X	X	X			
i. Cardiac pacing capabilities;	X	X	X	X	X			
ii. Electrocardiograph;	X	X	X	X	X			
iii. Cardiac monitor with at least two pressure monitoring modules including cardiac output and hard copy recording; with capability to continuously monitor heart rate, respiratory rate, temperature;	X	X	X	X	X			
iv. Defibrillator;	X	X	X	X	X			
v. Portable transport monitor with ECG and pressure monitoring capability;	X	X	X	X	X			
vi. Blood pressure cuffs;	X	X	X	X	X			
vii. Doppler device;	X	X	X	X	X			
viii. Noninvasive blood pressure machine;	X	X	X	X	X			
d. Intravenous supplies, including:	X	X	X	X	X			
i. Standard IV fluids and administration devices appropriate for pediatric patients including:	X	X	X	X	X			
A. IV catheters;	X	X	X	X	X			
B. Intraosseous needles;	X	X	X	X	X			
C. Infusion sets and pumps with micro-infusion capabilities;	X	X	X	X	X			
D. Infusion controllers;	X	X	X	X	X			
ii. Adult and pediatric dosages/dilutions of medications;	X	X	X	X	X			
e. Sterile surgical sets, including:	X	X	X	X	X			
i. Thoracotomy set;	X	X	X	X	X			
ii. Chest tubes;	X	X	X	X	X			
iii. Emergency surgical airway sets;	X	X	X	X	X			
iv. Peritoneal lavage set;	X	X	X	X	X			

WAC 246-976-620

Equipment Standards for Trauma Service Designation (continued)

A facility with a designated trauma service must:	LEVELS							
	I	IP	II	IIP	III	IIIP	IV	V
f. Intracranial pressure monitoring devices;	X	X	X	X				
g. Gastric supplies, including NG tubes;	X	X	X	X	X			
h. Ability to provide thermal control equipment, including:	X	X	X	X	X			
i. Patient warming and cooling devices;	X	X	X	X	X			
ii. Blood and fluid warming device;	X	X	X	X	X			
iii. Expanded scale thermometer capable of detecting hypothermia;	X	X	X	X	X			
iv. Device for assuring warmth during transport;	X	X	X	X	X			
i. Other equipment, including:	X	X	X	X	X			
i. Ability to provide patient weighing devices;	X	X	X	X	X			
ii. Cardiac emergency cart.	X	X	X	X	X			

WAC 246-976-870
Trauma team activation

1. The purpose of trauma team activation is to assure all personnel and resources necessary for optimal care of the trauma patient are available when the patient arrives in the emergency department. To assure optimal patient care:
   a. Patient status must be reported from the field by prehospital providers to the emergency department in the receiving trauma service;
      i. It is the responsibility of the prehospital providers to record all relevant information and report it to the receiving trauma service; and
      ii. It is the responsibility of the receiving trauma service to request any relevant information that is not volunteered by the prehospital providers.
   b. The trauma service must use the prehospital information to determine activation of a trauma team and/or resources appropriate for the care of the patient; and
   c. The presence of the general surgeon, when included in your written scope of trauma service, is necessary to direct resuscitation, to exercise professional judgment that immediate surgery is not indicated, as well as to perform surgery when it is indicated, and to direct patient transfer if necessary.
2. A facility designated to provide trauma services must adopt and use a method for activating its full trauma team. The method must:
   a. Be based on patient information obtained from prehospital providers and other sources appropriate to the circumstances;
   b. Include mandatory presence of the general surgeon for levels I - III and for level IV if general surgery services are included in your written scope of trauma service (the surgeon must be at least a postgraduate year four for level I and II);
   c. Specify patient criteria for determining mandatory activation of the full trauma team;
   d. Be applied regardless of time post injury or previous care, whether delivered by EMS or other means, and whether transferred from the scene or from another hospital;
   e. The method for activation of the full trauma team may include response by a neurosurgeon instead of a general surgeon when, based on prehospital information, the mechanism of injury clearly indicates isolated penetrating trauma to the brain; and
   f. The trauma service must adopt a trauma quality improvement audit filter to monitor the appropriateness of and compliance with your full trauma team activation criteria.
3. A facility designated to provide trauma services may adopt and use a method for activating a modified trauma team. The method must:
   a. Specify patient criteria for determining activation of the modified trauma team;
   b. Include a mechanism to upgrade the level of trauma team response to full based on newly acquired information; and
   c. The trauma service must adopt a trauma quality improvement audit filter to monitor the appropriateness of and compliance with your modified trauma team activation criteria.

WAC 246-976-881
Trauma quality improvement programs for designated trauma care services

1. All designated levels I - V and pediatric levels I - III trauma services must have a quality assessment and improvement program conducted by the multidisciplinary trauma committee that reflects and demonstrates a process for continuous quality improvement consistent with your written scope of trauma service, with:
   a. An organizational structure that facilitates the process of quality assurance and improvement and identifies the authority to change policies, procedures, and protocols that address the care of the trauma patient;
   b. Developments of standards of quality care;
   c. A process for monitoring compliance with or adherence to the standards;
   d. A process of peer review to evaluate specific cases or problems identified by the monitoring process;
   e. A process for correcting problems or deficiencies;
   f. A process to analyze and evaluate the effect of corrective action; and
   g. A process to insure that confidentiality of patient and provider information is maintained according to the standards of RCW 70.41.200 and 70.168.090.

WAC 246-976-885
Educational requirements - Designated trauma service personnel

1. To allow for timely and orderly establishment of the trauma system, the department must consider that education requirements established in this chapter for all personnel caring for trauma patients in a designated trauma care service, have been met if:
   a. At the time of initial designation, twenty-five percent of all personnel meet the education and training requirements defined in this chapter;
   b. At the end of the first year of designation, fifty percent of all personnel meet the education and training requirements defined in this chapter;
   c. At the end of the second year of designation, seventy-five percent of all personnel meet the education and training requirements defined in this chapter; and
   d. At the end of the third year of designation, and in all subsequent designation periods, ninety percent of all personnel meet the education and training requirements defined in this chapter.
2. To meet the requirements for a trauma life support course:
   a. Emergency department registered nurses in levels I, II, III and IV trauma care services, and in levels I, II, and III pediatric trauma care services, must have successfully completed a trauma nurse core course (TNCC), or a department-approved equivalent that includes a minimum of sixteen contact hours of trauma-specific education on the following topics:
      i. Mechanism of injury;
      ii. Shock and fluid resuscitation;
      iii. Initial assessment;
      iv. Pediatric trauma; and
      v. Stabilization and transport.
   b. Registered nurses in critical care units in level I or II trauma services must have successfully completed a minimum of eight contact hours of trauma-specific education;
   c. Registered nurses in critical care units in level III trauma care services must have successfully completed a minimum of four contact hours of trauma-specific education; and
   d. For level IV services, if your written scope of trauma service includes critical care for trauma patients, registered nurses in critical care units must have successfully completed a minimum of four contact hours of trauma-specific education.

WAC 246-976-886
Pediatric education requirements (PER) for nonpediatric designated facilities

1. In designated levels I, II, III, and IV general trauma care services emergency physicians and emergency RNs who are involved in the resuscitation and stabilization of pediatric trauma patients shall have PER, as provided in subsection (3) of this section, appropriate to their scope of trauma care.
2. In designated levels I, II, and III general trauma care services general surgeons, anesthesiologists, CRNAs and PACU RNs who are involved in the resuscitation and stabilization of pediatric trauma patients shall have PER, as provided in subsection (3) of this section, appropriate to their scope of trauma care.
3. PER can be met by the following methods:
    a. One-time completion of pediatric advanced life support (PALS) or a substantially equivalent training course; or
    b. Current certification in ATLS; or
    c. Completion of a least five contact hours of pediatric trauma education during each designation period. PER contact hours will:
        i. Include the following topics:
            A. Initial stabilization and transfer of pediatric trauma;
            B. Assessment and management of pediatric airway and breathing;
            C. Assessment and management of pediatric shock, including vascular access;
            D. Assessment and management of pediatric head injuries;
            E. Assessment and management of pediatric blunt abdominal trauma;
        ii. Be accomplished through one or more of the following methods:
            A. Review and discussion of individual pediatric trauma cases within the trauma QA/QI program;
            B. Staff meetings;
            C. Classes, formal or informal;
            D. Web-based learning; or
            E. Other methods of learning which appropriately communicate the required topics listed in this section.

WAC 246-976-887
Pediatric education requirements (PER) for pediatric designated facilities.

1. In designated levels I, II, III pediatric trauma care services emergency physicians, emergency RNs, general surgeons, pediatric intensivists, anesthesiologists, CRNAs, ICU RNs and PACU RNs who are involved in the resuscitation, stabilization and in-patient care of pediatric trauma patients shall have PER, as provided in subsection (2) of this section, appropriate to their scope of trauma care.
2. PER can be met by the following methods:
    a. One-time completion of pediatric advance life support (PALS) or a substantially equivalent training course; or
    b. Current certification in ATLS; or
    c. Completion of at least seven contact hours of pediatric trauma education during each designation period. PER contact hours will:
        i. Include the following topics:
            A. Initial stabilization and transfer of pediatric trauma;
            B. Assessment and management of pediatric airway and breathing;
            C. Assessment and management of pediatric shock, including vascular access;
            D. Assessment and management of pediatric head injuries;
            E. Assessment and management of pediatric blunt abdominal trauma;
            F. Pediatric sedation and analgesia;
            G. Complications of pediatric multiple system trauma;
        ii. Be accomplished through one or more of the following methods:
            A. Review and discussion of individual pediatric trauma cases within the trauma QA/QI program;
            B. Staff meetings;
            C. Classes, formal or informal;
            D. Web-based learning; or
            E. Other methods of learning which appropriately communicate the required topics listed in this section.

WAC 246-976-890
Interhospital transfer guidelines and agreements

Designated trauma service must:

1. Have written guidelines consistent with the written scope of trauma service to identify and transfer patients with special care needs exceeding the capabilities of the trauma service.
2. Have written transfer agreements with other designated trauma services. The agreements must address the responsibility of the transferring hospital, the receiving hospital, and the prehospital transport agency, including a mechanism to assign medical control during interhospital transfer.
3. Have written guidelines consistent with the written scope of trauma service to identify trauma patients who are transferred in from other facilities, whether admitted through the emergency department or directly into other hospital services.
4. Use verified prehospital trauma services for interfacility transfer of trauma patients.

WAC 246-976-910
Regional quality assurance and improvement program

1. The department will:
   a. Develop guidelines for a regional EMS/TC system quality assurance and improvement program including:
      i. Purpose and principles of the program;
      ii. Establishing and maintaining the program;
      iii. Process;
      iv. Membership of the quality assurance and improvement program committee;
      v. Authority and responsibilities of the quality assurance and improvement program committee;
   b. Review and approve written regional quality assurance and improvement plans;
   c. Provide trauma registry data to regional quality assurance and improvement programs in the following formats:
      i. Quarterly standard reports;
      ii. Ad hoc reports as requested according to department guidelines.
2. Levels I, II, and III, and Level I, II and III pediatric trauma care services must:
   a. Establish, coordinate and participate in regional EMS/TC systems quality assurance and improvement programs;
   b. Ensure participation in the regional quality assurance and improvement program of:
      i. Their trauma service director or codirector; and
      ii. The RN who coordinates the trauma service;
   c. Ensure maintenance and continuation of the regional quality assurance and improvement program.
3. The regional quality assurance and improvement program committee must include:
   a. At least one member of each designated facility's medical staff;
   b. The RN coordinator of each designated trauma service; and
   c. An EMS provider.
4. The regional quality assurance program must invite the MPD and all other health care providers and facilities providing trauma care in the region, to participate in the regional trauma quality assurance program.
5. The regional quality assurance and improvement program may invite:
   a. One or more regional EMS/TC council members; and
   b. A trauma care provider who does not work or reside in the region.
6. The regional quality assurance and improvement program must include a written plan for implementation including:
   a. Operational policies and procedures that detail committee actions and processes;
   b. Audit filters for adult and pediatric patients;
   c. Monitoring compliance with the requirements of chapter 70.168 RCW and this chapter;
   d. Policies and procedures for notifying the department and the regional EMS/TC council of identified regional or state-wide trauma system issues, and any recommendations;
   e. Policies regarding confidentiality of:
      i. Information related to provider's and facility's clinical care, and patient outcomes, in accordance with chapter 70.168 RCW;
      ii. Quality assurance and improvement committee minutes, records, and reports in accordance with RCW 70.168.090(4), including a requirement that each attendee of a regional quality assurance and improvement committee meeting is informed in writing of the confidentiality requirement. Information identifying individual patients may not be publicly disclosed without the patient's consent.

Exhibit B

Trauma Service Designation Definitions

Designated Trauma Service Levels in Washington State – I, II, III, IV, and V adult acute care; I, II, and III pediatric acute care; I, II, and III adult rehabilitation; and I pediatric rehabilitation.

Designation – a formal determination by the Department of Health that hospitals or health care facilities are capable of providing trauma services as designated in RCW 70.168.070.

Diversion – EMS transport of a trauma patient past the usual receiving trauma service to another trauma service due to temporary unavailability of trauma care resources at the usual receiving trauma service.

Emergency Medical Services and Trauma Care Regions – the geographic areas within the state established by Department of Health.

Emergency Medical Services and Trauma Care System Plan – a statewide plan that identifies all emergency medical services and trauma care objectives, priorities, equipment, personnel, training, and other needs required to maintain a viable statewide trauma system. The plan also outlines the implementation of state, regional, and local activities that will maintain and enhance the system. The plan is formulated by compiling all regional emergency medical services and trauma care plans. It is updated every two years.

Interfacility Transfer – process in which the facility's medical staff assesses the patient and determines that a higher level of care is needed. The patient is then transferred to a higher-level trauma service.

Level I (Adult and Pediatric) Trauma Service – provides the highest level of definitive and comprehensive surgical and medical care for trauma patients with multiple and complex injuries requiring the most specialized care. Trauma-trained emergency physicians, registered nurses, and general surgeons are in-house and available to the trauma patient within 5 minutes to initiate resuscitation and stabilization, and to direct patient care. A Level I must conduct applicable trauma research and injury prevention activities, provide statewide professional and community education, and consultative community outreach services.

Level II (Adult and Pediatric) Trauma Service – provides definitive comprehensive surgical and medical care for multi-system trauma patients. Trauma-trained emergency physicians and registered nurses are in-house and available to the trauma patient within 5 minutes to initiate resuscitation and stabilization. A trauma trained general surgeon is available within 20 minutes to direct patient care. A broad range of specialists, comprehensive diagnostic capabilities, and support services are available. Injury prevention activities, professional and community education, and consultative community outreach services are provided.

Level III (Adult and Pediatric) Trauma Service – provides comprehensive surgical and medical care for trauma patients. Trauma-trained emergency physicians and registered nurses are in-house and available within 5 minutes to initiate resuscitation and stabilization. A trauma trained general surgeon is available within 30 minutes to direct patient care. The general surgeon may provide treatment including surgery, or initiate transfer to a higher-level trauma service. Select specialty, diagnostic, and support services are available. Injury prevention activities are provided.

Level IV Trauma Service – provides initial resuscitation and stabilization. Trauma-trained registered nurses are in-house and available within 5 minutes to initiate resuscitation and stabilization, and trauma-trained physicians are on-call and available within 20 minutes to provide resuscitation, stabilization, and treatment, and to initiate transfer. Trauma-trained general surgeons and trauma critical care services may be available, but are not required. Standard diagnostic and support services are provided.

Level V Trauma Service – provides initial resuscitation, stabilization, and transfer of trauma patients. Trauma-trained physicians, physician assistants, or advanced registered nurse practitioners are available within 20 minutes. Level V facilities are rural hospitals or clinics.

Level I (Adult and Pediatric) Trauma Rehabilitation Service – provides in-patient rehabilitative treatment to trauma patients with traumatic brain injuries, spinal cord injuries, complicated amputations, and other diagnoses resulting in moderate to severe functional impairment.

Level II Trauma Rehabilitation Service – provides in-patient rehabilitative treatment to trauma patients with musculoskeletal trauma, peripheral nerve injuries, lower extremity amputations, and other diagnoses resulting in moderate to severe functional impairment.

Level III Trauma Rehabilitation Service – provides out-patient rehabilitative treatment to trauma patients with limited musculoskeletal injuries, peripheral nerve injuries, uncomplicated lower extremity amputations, and other diagnoses resulting in minimal to moderate functional impairment.

Major Trauma – a patient with a single injury or multisystem injuries that requires immediate medical or surgical intervention to prevent death, and/or requires comprehensive in-patient care to prevent disability. These injuries usually result in a total Injury Severity Score of 16 or greater.

Pediatric Trauma Patient – a trauma patient known or estimated to be less than fifteen years of age.

Physician with Specific Delineation of Surgical Privileges – a physician with surgical privileges delineated for emergency/life-saving surgical intervention and stabilization of a trauma patient prior to transfer to a higher level of care. Surgery privileges are awarded by the facility's credentialing process.

Prehospital Trauma Triage Procedures – the method used by prehospital providers to evaluate injured patients and determine whether to activate the trauma system from the field. It is described in WAC 246-976-930(2).

Quality Improvement (QI) – a process/program to monitor and evaluate care provided in trauma services and EMS/TC systems.

Scope of Trauma Service – the minimum range of capabilities routinely available at a trauma service. It is determined by the trauma service by using standards of care in compliance with its designated level of trauma service.

Special competence – an individual has been deemed competent and committed to a medical specialty area with documented training, board certification and/or experience, which has been reviewed and accepted as evidence of a practitioner's expertise:

- For physicians, by the facility's medical staff.
- For registered nurses, by the facility's department of nursing.
- For physician assistants and advanced registered nurse practitioners, as defined in the facility's bylaws.

Standards of Care – a written framework of the components of care including assessment, diagnosis, management, and evaluation procedures. Should also include key quality indicators, specific measurement criteria, skills, equipment, processes, personnel, and performance aspects.

Trauma Medical Director – the provider with oversight responsibility for the organization, direction, and quality improvement of the trauma service.

Trauma Nurse Coordinator – a registered nurse with special competence in the care of the injured adult and child, with the authority and responsibility to monitor, coordinate, and organize the trauma service. Also includes responsibilities for quality assessment and improvement, clinical and system oversight, education, and regulatory compliance.

Trauma Registry Coordinator – a person with special competence in medical terminology, auditing and abstraction, coding, and computer and software use, with the authority and responsibility to casefind, report, and track trauma patients meeting registry inclusion criteria, and to manage the trauma registry.

Trauma Rehabilitation Coordinator – a person designated to facilitate early rehabilitation interventions and the trauma patient's access to a designated rehabilitation center.

Trauma System – an organized approach to providing personnel, facilities, and equipment for effective and coordinated medical treatment of patients with injuries requiring immediate medical or surgical intervention to prevent death or disability. The trauma system includes injury prevention activities, prehospital care, hospital care, and rehabilitation.

Trauma Team Activation – the automatic response of a predetermined group of clinical providers to rapidly provide initial evaluation, resuscitation, and treatment to the trauma patient. A full trauma team activation requires the general surgeon to automatically respond to the patient's bedside. The activation of the trauma team is based on prehospital data, or in-house data for patients that arrive by privately owned vehicle (POV).

Exhibit C

Frequently Asked Questions

1. Q: Why do we have to apply for trauma service designation, when we are already designated?
   A: Trauma designation rules require that DOH conduct a competitive application process every three years. The re-designation process allows for new hospitals to apply and compete (if necessary) for trauma designation. Also, currently designated hospitals may gracefully back out of their commitment, or apply and compete (if necessary) for a higher-level trauma designation. Additionally, the re-designation process provides an opportunity for the hospital and physicians to reaffirm their commitment to trauma care. The Department of Health is able to reassess the system, make adjustments as needed, and reaffirm to the public that standards of care are being met and resources are available throughout the state as needed.

2. Q: If we apply for a higher level designation, but we cannot meet all of the standards, are we automatically designated at the lower level?
   A: A slot must exist in your region, and then DOH must handle those decisions on a case-by-case basis.

3. Q: What does "provisional designation" mean?
   A: When necessary to ensure adequate trauma care in specific areas of the state, DOH has authority to provisionally designate a trauma service that is not able to meet all of the designation requirements. Provisional designation is for no more than two years and usually requires a follow-up site review prior to awarding full designation status.

4. Q: Does the application have to have page numbers?
   A: Application page numbers help the reviewers keep your application pages in order, and assure that pages are not missing. Page numbers can be applied as simply as handwriting numbers on the lower corner of each page on the original when it is finalized, so that subsequent photocopies have the same page numbers.

5. Q: Can the completed application be submitted electronically?
   A: No, it is too difficult to reconstruct and put together. You will have some documents that are not available electronically, which also need to be added to the completed application.

6. Q: How should the questions requiring a narrative be answered?
   A: Answers can be in depth or bulleted, to the point is usually best. Choose as appropriate.

7. Q: In the "Trauma Service Administration" section, where it asks for "significant accomplishments or changes to the trauma service," can this be a bulleted list?
   A: Yes, either a bulleted list or a narrative description would be fine.

8. Q: If our hospital has had to deal with serious organizational problems (such as three administrators in a two-year period), should I include that information in the application?
   A: Yes, explain that in the "Trauma Service Administration" section, question one, where we ask about trauma service changes over the previous designation cycle.

9. Q: In the "Trauma Service Component" section of the application, does each item listed in the "Standards of Care" sections need to be addressed?
   A: No, there is no need to describe how your facility meets each trauma service standard of care (WAC standards). However, each "Assurance" section directly after each "Standards of Care" section must be answered. If your facility does not meet a specific standard of care, you must explain how the service will be brought into compliance for each, including a completion date. Also, all questions and requests for materials listed in the "Documentation" section must be addressed and submitted.

10. Q: Can a policy be referred to throughout the application, without putting a copy of it in all the sections where it applies?
    A: Yes, however, in some sections we explicitly ask for data with an explanation and analysis, not just a copy or referral to a policy.

11. Q: What if I don't have control over participation grant money?
    A: Trauma Coordinators should know where that money is spent. Having control over it, in an account separate from the ED or general fund, would be best. DOH may ask for a more specific accounting of that money in future applications. That money is to be spent in support of your trauma service.

12. Q: What is the purpose of the Scope of Service?
    A: We frequently need to know what the state's resources are. Not all Level III's, for instance, have the same resources. The Scope of Service document will enable us to have a better inventory of services across the state.

13. Q: In the "Scope of Trauma Service" section, "Surgery Dept.," who should be included?
    A: The questions only refer to your general surgeons.

14. Q: If we activate a full trauma team, but we know the patient is probably going to be transferred out, does the general surgeon have to see the patient anyway?
    A: Yes, the purpose of trauma team activation is to use patient information from the field to identify trauma patients who would benefit from evaluation and treatment by a general surgeon upon their arrival in the ED, regardless of whether the patient would be admitted or transferred. Trauma services are required to develop and follow their patient criteria that trigger mandatory activation of the general surgeon. (Also, for registry purposes, it is important to be consistent to have accurate statewide data analysis. A full activation requires the general surgeon to respond to the patient bedside automatically.)

15. Q: Can a general surgeon be on call at more than one facility at a time?
    A: WAC rules are clear about the required response times for general surgeons. If the on-call general surgeon is unavailable because he/she is managing trauma patient care, or performing elective surgery at another facility, then the facility calling the trauma team activation would need to go on divert, and that facility would not be meeting trauma standards of care.

16. Q: Should a general surgeon be performing elective surgery while on trauma call?
    A: If your general surgeon is performing elective surgery while on call, then your service is not meeting the trauma standards established in WAC. A surgeon back-up system is necessary if this is a recurring situation.

17. Q: Is it appropriate for a general surgeon's PA to respond to the ED for a full trauma team activation when the general surgeon is in the OR?
    A: The general surgeon must see the patient within the required response time. The ED physician and surgical PA can begin care until the prompt arrival of the general surgeon.

18. Q: If EMS reports an isolated head trauma, can the neurosurgeon substitute for the general surgeon when a full trauma team activation is called?
    A: Only if the mechanism of injury is clearly penetrating. In blunt trauma, the first appropriate surgeon for response is the general surgeon, although the neurosurgeon is a welcome addition. "The method for activation of the full trauma team may include response by a neurosurgeon instead of a general surgeon, when based on prehospital information, the mechanism of injury clearly indicates isolated penetrating trauma to the brain;" WAC 246-976-870.

19. Q: Does question 1 on page 9 of the application, asking for admission criteria for trauma patients, refer to ED admission or inpatient admission?
    A: It refers to inpatient admission criteria. You are not required to have admission criteria, but if you do, then we want a copy. DOH would like to know that your admission and transfer criteria reflect your scope of service. Your trauma service should have a plan for patients and injuries that they can provide care for, and for patients whose needs exceed your capabilities. The transfer and/or admission criteria should be specific about capabilities on a daily basis.

20. Q: For our admission criteria, can we just send you our general hospital Transfer and Referral of Patient's policy, our general Diversion policy, our Bed Placement policy, and our standards of care?
    A: It is unlikely that these policies will meet our documentation standards for admission criteria specific to trauma. The admission criteria for trauma patients should be based on what types of injuries you predictably receive over time, which ones you are capable of admitting and providing care for, and what physician services usually admit these patients. It is not necessary to list all possible types of injuries. Here are some examples:

    Orthopedic injuries: Our orthopedic surgeons admit and care for the majority of orthopedic injuries such as traumatic extremity fractures including simple pelvic fractures and vertebral fractures without neuro deficits, dislocations, ligamentous injuries, tendon lacerations, extremity amputations.

    Thoracic injuries: Our general and/or vascular surgeons admit and care for the majority of thoracic injuries, such as hemo/pneumothoraces, rib fractures, flail chests, lung lacerations, vascular injuries, diaphragm injuries.

    Then your transfer criteria should complement your admission criteria, such as:

    Orthopedic injuries: Our trauma service stabilizes and transfers patients with complex pelvic fractures, to ABC Hospital or to PQR Medical Center. Patients with vertebral fractures and neuro deficits are stabilized and transferred to ABC Hospital.

    Thoracic injuries: Our trauma service stabilizes and transfers patients with myocardial penetrations and massive or crushing chest injuries.

21. Q: What is the standard of care for the OR?
    A: (WAC 246-976-535) Level I-IV facilities must have an RN or designee who opens and prepares the OR within 5 minutes of TTA. This would include activities such as unlocking doors, turning on lights, turning on warmer, pulling out (not opening) trays, setting up OR chart forms. This person might also call the OR crew and get direction about what trays should be pulled for the type of injuries anticipated. This person could even be a central supply technician.

22. Q: Tracking diversions – what is acceptable for trauma designated hospitals?
    A: DOH will accept your statement that your facility doesn't ever divert trauma patients and there is no tracking done. However, if services are not available for trauma patient care such as equipment; beds; surgeons (e.g. neuro); etc., and you divert a patient from the field, then that would be a divert. If you feel a patient would be better served at a facility with a comparable designation and you divert the patient, while acceptable, this should be tracked.

23. Q: In the "Staff Resource List with Education & Training" section, the "Emergency Department" table, who should be included in the list of physicians?
    A: Only include the physicians that generally staff the ED.

24. Q: Not all staff have met the education requirements. Is there any allowance for new staff?
    A: Ninety percent of all trauma personnel must meet the education and training requirements at any given time. The intent of the ninety percent rule is to allow time for new hires to receive the appropriate trauma training. If your facility is temporarily out of compliance with this rule, you must submit a written plan of compliance with an expected completion date in your application for re-designation.

25. Q: Do staff have to be current in the required courses (ACLS, ATLS, TNCC, PALS, etc.)?
    A: No, trauma designation rules simply require providers to have taken the course at least once during their career. Many hospitals require staff to maintain currency, which is commendable, but not required.

26. Q: If our physicians refuse to take ATLS and other required courses, how can we get the physicians to comply?
    A: If staff are not in compliance with education and training requirements, the hospital must take action. Non-compliance could result in a provisional trauma designation from DOH. DOH is advised on setting these standards and requirements by physicians and nurses from across the state. Most of the State's trauma services have been designated for 15 years. The WAC rule about a 90% compliance rate was written that way to allow for new hires, who should be in compliance within a year. We have asked for more specific information in this application so those staff may be named in the final report. Using participation grant money for physician and nurse training might be a way to obtain compliance. (Pediatric Education Requirement (PER) compliance is a little different, see question 27.)

27. Q: How are facilities accomplishing PER for physicians?
    A: There are several ways such as PALS once a lifetime or every three years: current ATLS verification; or 5-7 hours of pediatric trauma QI; or informal/formal education covering stabilization, transfer, airway/breathing, pediatric shock and vascular access, head injuries, and blunt abdominal trauma. There are multiple options, creativity is encouraged. Pediatric trauma QI is very desirable and very effective using charts from your own trauma service. On-line pediatric trauma education from UW is being developed, but is not yet available (perhaps by 9/05). There are some other on-line CME resources for pediatric trauma. (See WAC 246-976-886 or 887 for the applicable requirements.)

28. Q: What topics must be included in the trauma-specific education for critical care nurses?
    A: Currently, there are no specific topic requirements. The education must address critical care trauma nursing. Although regular continuing trauma nursing education is desirable for every critical care nurse, this education is only required once in a nurse's career, WAC 246-976-885. The trauma nurse coordinator has the responsibility of determining the appropriateness of program content.

29. Q: In the "Quality Improvement" section, can we use a QI system issue that isn't resolved?
    A: Yes, just make sure you explain how you are working to close the loop on the issue.

30. Q: What if I haven't had to address a system issue in this last designation cycle?
    A: Then just say that. We ask you to list all of your filters, so we will know that you are looking at system issues through your QI program.

31. Q: For QI question number 5 (c), does the sample case have to have been taken to Regional QI?
    A: No, DOH is interested in your internal QI process. If the case went to Regional QI then that is an added piece of the QI puzzle, and we'd like to know how you shared what you learned.

32. Q: What are some best practices for trauma QI in small facilities?
    A: Some small facilities have invited surgeons from other areas to review their trauma cases, and attend a trauma QI committee meeting to provide input and education. These have been successful in bringing new information to the community physicians, enhancing the relationship between sending and receiving facilities and staff, and providing objective review of trauma care.

33. Q: What is the purpose of Regional QI? What cases should be brought to Regional QI?
    A: The purpose is for caregivers to evaluate and improve the performance of the Washington State trauma system. Broad cases such as those involving EMS and the regional system, patient destination decisions, transfers, collaboration of more than one agency/facility, or cases providing specific educational benefit are appropriate for Regional QI.

34. Q: What is learned at Regional QI versus hospital QI?
    A: The focus of Regional Trauma QI is determined by the members of the committee, and usually addresses broad trauma system issues that need actions or input by several entities, or is an opportunity for learning that benefits all facilities within the region. In hospital QI, the facility's trauma committee identifies in-house and provider-based processes or performances that need improvement, develops action plans, and evaluates the final outcome to close the loop. Hospital QI also provides educational opportunities.

35. Q: Have response times been changed in WAC, specifically regarding technicians?
    A: No, clinical lab technologist and radiological technician response times have not changed.

36. Q: Does a facility's program for EMS training of invasive procedures need to be formal?
    A: This is not a new WAC requirement. A formal training program is preferred.

37. Q: Where can the Hospital Trauma Registry Data Dictionary be found?
    A: On the DOH website at www.doh.wa.gov/hsqa/emstrauma/download/hospitaldictionary.pdf

38. Q: HIPPA has become a problem when trying to follow-up on patients at receiving hospitals.
    A: Harborview Medical Center (HMC) has set up a U-Link system for physicians to access electronic info on referred patients. Call the Physicians Liaison Program at 206-731-8846 (HMC) to sign up; or www.uwmedicine.org/patientcare/informationforhealthcareprofessionals/makeareferral/ulink.htm. For other facilities, call the Trauma Coordinator directly for follow-up.

39. Q: Do we have to test all trauma patients for alcohol?
    A: No, trauma designation rules do not require you to test for drugs or alcohol. However, there are required data elements in the Collector software for BAC Tox screen results. In the past, in the trauma service designation application, DOH asked trauma services to provide a policy for assessment and intervention for trauma patients admitted with a positive blood alcohol level or drugs of intoxication screen. Research demonstrates that assessing and addressing drug and alcohol abuse as part of the initial trauma assessment reduces the rate of trauma recidivism.

40. Q: How do we get a transfer agreement, & what facilities do we have to have an agreement with?
    A: You are required to have a transfer agreement with all designated trauma services that receive your trauma patients. Contact the Trauma Service Coordinator at the receiving trauma service to initiate a standard trauma transfer agreement.

41. Q: Where can I find the American Burn Association's transfer guidelines?
    A: To access the guidelines go to, http://www.ameriburn.org/pub/guidelinesops.pdf

42. Q: Our facility does not provide rehab care. How should we answer the requirement to describe the process to screen and refer patients to rehab services?
    A: Each facility should have personnel who can evaluate the trauma patient's need for referral for trauma rehabilitation. These might include the attending surgeon, physical, occupational, and/or speech therapy staff. The receiving trauma rehabilitation facility and physiatrist can also provide guidance by phone.

Exhibit D

Resource List

If you are a new Trauma Service Coordinator (TSC) or have never completed a trauma service designation application, there are TSC's that can help. Even if a TSC listed below is at a different level trauma service than yours, they have experience and can offer assistance with most aspects of the application.

Regions	**Contact by Level**
Central	Level I & Level I Pediatric Chris Martin, RN 206▪731▪3345 Harborview Medical Center ▪ Seattle clmartin@u.washington.edu Level III Debbi Mitchell, RN 253▪333▪2561 Auburn Regional Medical Center ▪ Auburn debbi.mitchel@uhsinc.com Young Kim, RN 425▪228▪3440 Valley Medical Center ▪ Renton young_kim@valleymed.org Becky Martin, RN 425▪688▪5701 Overlake Hospital Medical Center ▪ Bellevue rebecca.martin@overlakehospital.org
East	Level II Connie Pitts, RN 509▪473▪7183 Deaconess Medical Center ▪ Spokane pittscr@empirehealth.org Level II & Level III Pediatric Paula Hornbeck, RN 208▪799▪5458 St. Joseph Regional Medical Center ▪ Lewiston phornbeck@sjrmc.org Level III Lisa Foster, RN 509▪252▪6315 Holy Family Hospital ▪ Spokane fosterl@holy-family.org
North	Level II Patrick Michaelis, RN 360▪738▪6300 St. Joseph Hospital ▪ Bellingham pmichaelis@peacehealth.org

Regions	Contact by Level
North Central	Level II & Level III Pediatric Suzi Perrin, RN 509▪662▪1511 Central Washington Hospital ▪ Wenatchee suzanne.perrin@cwhs.com
South Central	Level III & Level III Pediatric Susan Leathers, RN 509▪525▪3320 St. Mary Medical Center ▪ Walla Walla leathers@smmc.com Level III Kim Dokken, RN 509▪735▪1095 Tri-Cities Trauma Service ▪ Tri-Cities kdokken@tcsharedservices.com
Southwest	Level II Denise Haun-Taylor, RN 360▪514▪1675 Southwest Washington Medical Center ▪ Vancouver dhauntay@swmedctr.com
West	Level II Barbara Carrier, RN 253▪426▪6845 St. Joseph Medical Center ▪ Tacoma barbcarrier@chiwest.com Linda Casey, RN 253▪968▪1241 Madigan Army Medical Center ▪ Ft Lewis linda.casey@nw.amedd.army.mil Karen Kiesz, RN 253▪403▪7758 Tacoma General Hospital ▪ Tacoma karen.kiesz@multicare.org Level III Linda Hubbard, RN 360▪537▪5406 Grays Harbor Community Hospital ▪ Aberdeen lhubbard@whnet.org Laurie Gaston, RN 360▪493▪4587 St. Peter Hospital ▪ Olympia Laurie.gaston@providence.org

Exhibit E

Washington State Trauma Registry Inclusion Criteria

(*Effective January 31, 2002*)

Data must be reported to the Washington Trauma Registry (WTR) for all patients with a discharge ICD9-CM diagnosis code of 800-904, or 910-959, or 994.1 (drowning), 994.7 (asphyxiation), or 994.8 (electrocution) AND any one or more of the following:

- All patients (any diagnosis) for whom the Trauma Resuscitation Team was activated; or
- All trauma patients who were dead on arrival at your facility; or
- All trauma patients who died in your facility; or
- All trauma patients transferred out to another facility by EMS/ambulance; or
- All trauma patients transferred in from another facility by EMS/ambulance; or
- All pediatric (age 0-14) trauma patients admitted to your facility; or
- All adult (age 15+) trauma patients admitted to your facility with length-of-stay more than 2 days (48 hours)

Note: *The diagnosis codes above include all subcodes; e.g., 806 includes 806.00-806.99.*

While **isolated hip fractures/femoral neck fractures** (ICD9-CM 820 with no other significant injuries noted) in elderly patients are included in registry requirements, WAC 246-976-420, *DOH does not require you to report those injuries at this time. It is applicable to patients 65 and older.*

Patients with diagnoses of **foreign bodies** (ICD9-CM 930-939) are required to be included in the registry **only if** there is a resulting injury. In these cases, the resulting injury should be coded in addition to the foreign body.

Transfers: Patients sent from one hospital to another hospital via private vehicle (non-ambulance) are not considered transfers for the purpose of inclusion. It is expected that patients with serious injuries will be transferred via ambulance, and that private vehicles are used only for patients with minor injuries.

Admitted to your facility: Patients moved from the emergency department to any bed in the hospital are considered admitted to the facility.

Readmissions: The Trauma Registry does not require readmission records for the same injury. Only the initial episode of care (first admission) is required. Exception: If a patient is discharged home from the emergency department and is subsequently admitted for a missed diagnosis of the same injury, both records should be included.

Trauma services may include additional patients that do not meet the state inclusion criteria. However, hospital comparative reports, regional quality improvement reports, and other state-prepared reports will only reflect records that meet the state criteria. This helps assure comparability across facilities and regions.

A detailed list of the discharge diagnosis codes for registry inclusion are provided below. Refer to ICD9-CM documentation for all sub-object detail. **Required ICD9-CM Injury Diagnoses:**

800 Fx of vault of skull
801 Fx of base of skull
802 Fx of Face bones
803 Other and unqualified skull fxs
804 Multiple fx involving skull or face with other bones
805 Fx of vertebral column without mention of spinal cord injury
806 Fx of vertebral column with spinal cord injury
807 Fx of rib(s), sternum, larynx, and trachea
808 Fx of pelvis
809 Ill-defined fx of bones of truck
810 Fx of clavicle
811 Fx of scapula
812 Fx of humerus
813 Fx of radius and ulna
814 Fx of carpal bone(s)
815 Fx of metacarpal bone(s)
816 Fx or one or more phalanges of hand
817 Multiple fxs of hand bones
818 Ill-defined fx of upper limb
819 Multiple fxs involving both upper limbs, and upper limb with rib(s) and sternum
820 Fx of neck of femur (or hip fx) (optional)
821 Fx of other and unspecified parts of femur
822 Fx of patella
823 Fx of tibia and fibula
824 Fx of one or more tarsal and metatarsal bones
825 Fx of calcaneus
826 Fx of one or more phalanges of foot
827 Other, multiple, and ill-defined fx of lower limb
828 Multiple fxs involving both lower limbs, lower with upper limb, & lower limb(s) with rib(s) & sternum
829 Fx of unspecified bones
830 Dislocation of jaw
831 Dislocation of shoulder
832 Dislocation of elbow
833 Dislocation of wrist
834 Dislocation of finger
835 Dislocation of hip
836 Dislocation of knee
837 Dislocation of ankle
838 Dislocation of foot
839 Other, multiple, and ill-defined dislocations
840 Sprains and strains of shoulder and upper arm
841 Sprains and strains of elbow and forearm
842 Sprains and strains of wrist and hand
843 Sprains and strains of hip and thigh
844 Sprains and strains of knee and leg
845 Sprains and strains of ankle and foot
846 Sprains and strains of sacroiliac region
847 Sprains and strains of other and unspecified parts of back
848 Other and ill-defined sprains and strains
849 Unspecified site of sprain and strain
850 Concussion
851 Cerebral laceration and contusion
852 Subarachnoid, subdural, and extradural hemorrhage following injury
853 Other and unspecified intracranial hemorrhage following injury
854 Intracranial injury of other & unspecified nature
860 Traumatic pneumothorax and hemorrhage
861 Injury to heart and lung
862 Injury to other & unspecified intrathoracic organs
863 Injury to gastrointestinal tract
864 Injury to liver
865 Injury to spleen
866 Injury to kidney
867 Injury to pelvic organs
868 Injury to other intra-abdominal organs
869 Internal injury to unspecified or ill-defined organs
870 Open wound of ocular adnexa
871 Open wound of eyeball
872 Open wound of ear
873 Other open wound of head
874 Open wound of neck
875 Open wound of chest wall
876 Open wound of back
877 Open wound of buttock
878 Open wound of genital organs (external) including traumatic amputation
879 Open wound of other and unspecified sites, except limbs
880 Open wound of shoulder and upper arm
881 Open wound of elbow, forearm, and wrist
882 Open wound of hand except finger(s) alone
883 Open wound of finger(s)
884 Multiple & unspecified open wound of upper limb
885 Traumatic amputation of thumb (complete) (partial)
886 Traumatic amputation of other finger(s) (complete) (partial)
887 Traumatic amputation of arm & hand (complete) (partial)
890 Open wound of hip and thigh
891 Open wound of knee, leg (except thigh), & ankle
892 Open wound of foot except toe(s) alone
893 Open wound of toe(s)
894 Multiple & unspecified open wound of lower limb
895 Traumatic amputation of toe(s) (complete) (partial)
896 Traumatic amputation of foot (complete) (partial)
897 Traumatic amputation of leg(s) (complete) (partial)
900 Injury to blood vessels of head and neck
901 Injury to blood vessels of thorax
902 Injury to blood vessels of abdomen & pelvis
903 Injury to blood vessels of upper extremity

904 Injury to blood vessels of lower extremity and unspecified sites
910 Superficial injury of face, neck, & scalp except eye
911 Superficial injury of trunk
912 Superficial injury of shoulder and upper arm
913 Superficial injury of elbow, forearm, and wrist
914 Superficial injury of hand(s) except finger(s) alone
915 Superficial injury of fingers
916 Superficial injury of hip, thigh, leg, and ankle
917 Superficial injury of foot and toes(s)
918 Superficial injury of eye and adnexa
919 Superficial injury of other, multiple, and unspecified sites
920 Contusion of face, scalp, and neck except eye(s)
921 Contusion of eye and adnexa
922 Contusion of trunk
923 Contusion of upper limb
924 Contusion of lower limb and of other and unspecified sites
925 Crushing injury of face, scalp, and neck
926 Crushing injury of trunk
927 Crushing injury of upper limb
928 Crushing injury of lower limb
929 Crushing injury of multiple and unspecified sites

For ICD9-CM 930-939, foreign bodies are required only if an injury results. In these cases, the resulting injury diagnosis should also be coded along with the foreign body diagnosis.

930 Foreign body on external eye
931 Foreign body in ear
932 Foreign body in nose
933 Foreign body in pharynx and larynx
934 Foreign body in trachea, bronchus, and limb
935 Foreign body in mouth, esophagus, & stomach
936 Foreign body in intestine and colon
937 Foreign body in anus and rectum
938 Foreign body in digestive system, unspecified
939 Foreign body in genitourinary tract
940 Burn confined to eye and adnexa
941 Burn of face, head, and neck
942 Burn of trunk
943 Burn of upper limb, except wrist and hand
944 Burn of wrist(s) and hand(s)
945 Burn of lower limb(s)
946 Burns of multiple specified sites
947 Burn of internal organs
948 Burns classified according to extent of body surface involved
948 Burn, unspecified
950 Injury to optic nerve and pathways
951 Injury to other cranial nerve(s)
952 Spinal cord injury without evidence of spinal bone injury
953 Injury to nerve roots and spinal plexus
954 Injury to other nerve(s) of trunk, excluding shoulder and pelvic girdles
955 Injury to peripheral nerve(s) of shoulder girdle and upper limb
956 Injury to peripheral nerve(s) of pelvic girdle and lower limb
957 Injury to other and unspecified nerves
958 Certain early complications of trauma
959 Injury, other early complications of trauma
994.1 Drowning and nonfatal submersion
994.7 Asphyxiation and strangulation
994.8 Electrocution & nonfatal effects of electric current

Washington State Trauma Registry Inclusion Criteria

Revised July 2002

Does the patient have a discharge diagnosis (ICD9-CM) code of 800-904, 910-959, or 994.1 (drowning), 994.7 (asphyxiation), or 994.8 (electrocution)?